NATIONAL HEALTH SERVICE CORPS EDUCATIONAL PROGRAM FOR CLINICAL AND COMMUNITY ISSUES IN PRIMARY CARE

MENTAL HEALTH MODULE

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CONTENTS

SUBTOPIC 1

SCHIZOPHRENIA

TIMELINE (60 minutes)

10 min	Introduction/Ice Breaker
5 min	Review of Objectives
10 min	Overview
25 min	Review of Case/Questions
10 min	Additional Discussion

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners/trainees, nurses, physician assistants/trainees, mental health workers, and other health professionals.

By the end of this discussion, participants should:

1. Describe several approaches to working with severely mentally ill patients in primary care practice

2. Discuss the general signs, symptoms, and clinical course of schizophrenia

3. Describe the major pharmacological and psychosocial interventions with this disorder

4. Understand the importance of working with the families of the seriously mentally ill and have some strategies to bring to this work

5. Recognize several key barriers to treatment

Note to Facilitators

Discussing serious mental illness may be stressful for individuals trained to work with medical or surgical patients. Often these clinicians feel patients with psychiatric disorders are among the most frustrating and unsatisfying patients they treat. Allowing a few minutes for the group to express responses to such patients early in the session may facilitate the presentation of objective material.

Ask the participants whether they have treated a patient with serious mental illness. How did their feelings about that patient differ from feelings they usually experience with patients with similar medical conditions? What was most frustrating about working with that patient?

SECTION 2 OVERVIEW

Mental health problems are among the most frequently encountered disorders in all health care settings. Psychotic disorders such as schizophrenia are among the most debilitating and persistent, although anxiety and mood disorders are far more common.

Primary care providers are likely to encounter a fair number of individuals with schizophrenia during their careers. The lifetime prevalence of this disorder is about 1.5 percent in the United States, and difficulties with access to care and compliance with treatment result in an increased morbidity for many disorders in those with schizophrenia.

Depending on the nature and location of a practice, a primary care clinician may be asked to be the primary provider of psychiatric medication as well as physical health care for a schizophrenic patient, with consultation from a psychiatrist who may see the patient only occasionally. Effective treatment of a schizophrenic's medical problems may require an understanding of the psychiatric disorder and an ability to tailor treatment to special needs, behaviors, and beliefs.

Basic Background

Schizophrenia equally affects men and women. Onset is usually between ages 15 and 25 years in men and somewhat later in women. Schizophrenia is over-represented among the poor, the socially isolated, and the homeless. Individuals with schizophrenia have a high mortality rate from accidents and natural causes. They have decreased access to health care services and an extremely high prevalence of suicide attempts (50 percent overall).

The cause of schizophrenia is unknown, although the condition's genetic basis is relatively well-established. Children with one schizophrenic parent develop the disease at about 12 times the rate of the general population, and a monozygotic twin of a someone with schizophrenia has almost a 50 percent chance of having schizophrenia.

Diagnosis and Treatment

Because every sign and symptom of schizophrenia can also be seen in other psychiatric and neurological disorders, a history and a careful mental status examination are essential for diagnosis. The condition frequently begins with an individual who is quiet, introverted, has few friends, and enjoys activities done alone. Usually symptoms develop slowly over many months or years. Family and friends may report that the person changed and began doing less well in school, work, or social relationships. Usually the individual first comes to medical attention because of unusual speech, bizarre ideas, reports of strange perceptions, or peculiar behavior. The diagnosis requires continuous signs of the disturbance for at least six months.

After diagnosis, schizophrenia generally involves alternating remissions and exacerbations. Often, initial deterioration is relatively rapid and then reaches a plateau. As many as a third of those

diagnosed recover significantly; another 20 to 30 percent continue to experience moderate symptoms; and about half never return to their premorbid level of functioning.

Treatment should involve medication, social supports (including housing and group activities), rehabilitation, and family-oriented interventions, as well as crisis and inpatient care when necessary. Depending on the accessibility of mental health services and the priorities of local funding agencies, antipsychotic medications may be the primary, or only, psychiatric treatment offered. Frequently, periodic hospitalization is required.

Social skills training is a highly structured form of group treatment that helps those with schizophrenia maximize the ability to function in the community and to maintain independence and social relationships. These interventions cover topics such as medication compliance, making and maintaining friends, and budgeting.

Individual psychotherapy, to provide support and information rather than insight, can be quite effective in helping those with schizophrenia deal with the effects of their illness. Establishing a trusting relationship can allow patients to decrease their paranoia, increase their interpersonal connectedness, and organize their thinking. An active therapist can help develop models of coping that can improve quality of life. A behavioral approach can be quite useful in helping patients alter ineffective or self-destructive behaviors.

Work with schizophrenic individuals frequently involves family or other support systems. Family members often feel guilty about having "caused" the schizophrenia. Often, they are bewildered by the patient's strange behaviors, and they feel frustrated and depressed. Educating family members about the illness and helping them find better ways of coping and working with their ill family member can dramatically reduce the severity of symptoms and the frequency of relapse.

The most severely disordered individuals with schizophrenia may only be able to manage in the community if they participate in regular day programs or live in community residences staffed by trained professionals. A small number will require 24-hour care. Frequently, these patients have other complicating conditions, such as traumatic brain injury, mental retardation, and severe personality disorders.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Mr. Johnson is a 33-year-old white male who came to your clinic complaining of a three-week history of frontal headaches lasting six to eight hours. He appeared somewhat odd, withdrawn and suspicious. His description of the severity of the headaches and how much they incapacitated him convinced you to do a fairly extensive workup. Results from a visit to his dentist and optometrist and a CT of his head have all been negative.

On this follow-up visit, you begin to explain your difficulty in figuring out what could be wrong. He looks at you strangely and then, in a whisper, explains that the headaches began after a fight with his landlord, whom he suspects is an FBI agent. He describes in detail how three weeks ago he was abducted during the night by a team of FBI agents who implanted a radio transmitter in his brain. He appears bewildered about how the agents got into his apartment, because the doors and windows were locked when he awoke in the morning.

Mr. Johnson tells a rambling story that includes multiple plots by his family and neighbors to extort from him a secret, which he refuses to discuss. He says that midway through his second year of law school, he gathered evidence proving that his international law professor worked for the Soviet Union. In "a plot to deny his discovery," he was hospitalized psychiatrically.

He lived for the next seven years with his parents, who "must have been in cahoots" with the government, because they kept on trying to convince him he was crazy. Although he took haloperidol and cogentin, "they didn't do anything except put me to sleep," so he stopped. After multiple disagreements with his parents and several hospitalizations, "my parents paid me off and told me to leave their home, but they still send me $1,000 a month."

Since then he has lived in four different apartments. Mr. Johnson becomes angry and hostile during further history taking, asking "You think I'm crazy too, don't you?" and is only minimally compliant with a physical examination.

1. What further examinations and diagnostic procedures might be helpful in understanding what is wrong with Mr. Johnson?

2. How might you approach Mr. Johnson's belief that there is nothing wrong with him psychiatrically?

3. Suppose you are practicing in a rural area where access to psychiatric services is difficult. What further information about Mr. Johnson's history might help you to better understand his psychiatric condition?

4. What other spheres of Mr. Johnson's life might be appropriate for you to address? In what areas might it be useful to enlist help from the local mental health center?

SECTION 4 SUGGESTED ANSWERS

1. *What further examinations and diagnostic procedures might be helpful in understanding what is wrong with Mr. Johnson?*

   Evaluation of psychotic and paranoid patients cannot be limited to inquiries into psychiatric status. Patients with severe mental illness may suffer from physical disorders as well. In fact, their avoidance of appropriate health care frequently leads to increased prevalence of a number of physical illnesses. Thus, medical causes for Mr. Johnson's headache must be sought and ruled out using the same protocol as would be appropriate for other patients.

   Demonstrating to Mr. Johnson that you take his complaints seriously can help establish rapport and trust, an essential basis for further evaluation of his psychiatric disorder.

2. *How might you approach Mr. Johnson's belief that there is nothing wrong with him psychiatrically?*

   Many severely mentally ill individuals deny that they have problems or ascribe their difficulties to outside forces. Rather than confronting this denial, it is often most useful to ally with patients around areas of shared belief.

   For someone like Mr. Johnson, who entered young adulthood with visions of a successful life as a professional, denial of the diagnosis of schizophrenia is not dissimilar to the common denial of a terminal diagnosis in medical patients. Because schizophrenia affects thought processes, overcoming denial of this diagnosis is often more difficult and time-consuming than for medical illnesses.

   One helpful strategy can be to agree to disagree. Rather than struggling for acceptance of a diagnosis, form an alliance around areas where Mr. Johnson does perceive difficulties and desires help. These might be in areas such as overcoming intrusive thoughts, developing social skills, or returning to a more productive life.

3. *Suppose you are practicing in a rural area where access to psychiatric services is difficult. What further information about Mr. Johnson's history might help you to better understand his psychiatric condition?*

   Because Mr. Johnson appears to be in no immediate danger, establishing a trusting relationship with him before probing too deeply into his psychiatric symptoms and history is essential. Once trust is established, however, the following questions can be useful in clarifying the diagnosis and formulating a treatment plan.

Onset: What was Mr. Johnson's premorbid history? Before college graduation, did he have many friends? Was he a loner? Did he have feelings and ideas that were not shared by his peer group?

Later onset, good premorbid functioning, and "positive" symptoms are associated with better prognosis in individuals with schizophrenia. Positive symptoms are those that seem to add something to the patient, for example, hallucinations, delusions, and bizarre beliefs. "Negative" symptoms include withdrawal, apathy, and asociality.

Course: How long was Mr. Johnson's initial hospitalization? Was he able to establish a reasonable relationship with those who treated him? Since then, how frequently and for how long has he been hospitalized? Did he participate in any post-hospital discharge plans, such as individual therapy, groups, social skills training, or other structured activities?

Sustained periods of relatively stable functioning and compliance with treatment are good prognostic signs.

Response to treatment: Have there been any medications that Mr. Johnson himself has found helpful?

Virtually all neuroleptics have the same mechanism of action—blockade of dopamine 2 (D2) receptors in the brain. However, the newer "atypical" or "novel" antipsychotic agents differ in the degree of D2 blockade as well as in their action on other neurotransmitter receptors (e.g., serotonin). The novel antipsychotic agents often have a decreased risk of causing movement disorders such as dystonias and tardive dyskinesia. Although side effects differ between the classic (typical) and the newer antipsychotic agents, therapeutic effect is similar. However, clozapine and some other atypicals often are particularly helpful with negative symptoms.

Because most antipsychotics do not differ widely in their therapeutic effects, the selection of an appropriate drug is usually a matter of choosing a medication with a side effect profile that the patient finds tolerable. Low-potency, typical medications (chlorpromazine, thioridazine) frequently have marked anticholinergic side effects, and higher-potency medications (haloperidol, fluphenazine) have extrapyramidal, Parkinson-like side effects. Newer medications each bring with them their own side effects, though many patients find these more tolerable than those produced by older medications.

Family history: Are there others in Mr. Johnson's family who have suffered from mental illness? How might you find out more about their diagnoses and responses to treatment?

Given the stigma frequently attached to such diagnoses, many patients report only that a relative "went off to a hospital" and are unable to give a specific diagnosis. Sometimes, when specifically questioned by family members "to help the doctors understand our son," relatives will provide additional information.

Supports: Is Mr. Johnson still in touch with his family regularly? Does he ever see them, or is his contact solely a matter of receiving their support checks? Has Mr. Johnson explored other means of financial support? Does he currently have people with whom he socializes? What does he do during the day, and what would he like to do?

Helping individuals secure reliable income, stable housing, and interpersonal relationships is a critical part of appropriate treatment for psychotic disorders.

4. *What other spheres of Mr. Johnson's life might be appropriate for you to address? In what areas might it be useful to enlist help from the local mental health center?*

Every primary care practitioner should know some of the available supports at community mental health centers and social service agencies. Because of the wide-ranging nature of the disabilities associated with chronic mental illness, individuals with this diagnosis will likely need an array of support services.

As mentioned in the response to Question 3, most individuals with schizophrenia qualify for federal income support, such as Social Security, and many may need the help of a money manager. Such services are often available through community mental health centers or Social Security offices.

Structured daytime activities, which can range from therapeutically oriented treatment programs to clubhouses where members can socialize with others who have similar disorders, can provide social support and interaction. Regular meetings with a mental health clinician and ongoing follow-up with a psychiatrist can provide the necessary mix of individual supports and medication monitoring.

Educating the families of these individuals about schizophrenia is an essential part of treatment. Many communities have branches of the National Alliance for the Mentally Ill, a support and advocacy group run by and for relatives of those with major mental illnesses. Referrals to such a group can often replace relatives' feelings of guilt and hopelessness with effective support and information from those in similar circumstances.

SECTION 5 ADDITIONAL EXERCISES

1. Often, family members of individuals with schizophrenia feel guilty about the role they may have played in "causing" the illness. Role-play the clinician explaining to Mr. Johnson's parents the nature of the illness, focusing on addressing their feelings of responsibility.

   The mother could be portrayed as interested in learning more about the origins of the disease and wondering how best to help her son without provoking his hostility and paranoia. The father could be portrayed as more interested in stopping his son's "goofy behavior and ideas," which he thinks are probably a result of something his wife did while raising their son. He is suspicious of you as well, stressing his annoyance that, like everyone else, "You'll make a big deal out of his craziness, rather than helping him with his headaches, which is what's really bothering him."

2. Mr. Johnson has now been taking medication for a year and has not had any significant relapses. He asks you to write an honest letter to an employer who is going to be interviewing him for a job as a mail room clerk. What would you want to know from Mr. Johnson, and how would you phrase your letter?

SECTION 6 SUGGESTED READING

1. *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Washington, DC: American Psychiatric Press; 1995.

   The classic diagnostic manual for psychiatric disorders. The section on schizophrenia provides an overview of characteristic symptoms, features, course, and differential diagnosis. It also sets forth diagnostic criteria.

2. GAP Committee on Psychiatry and the Community. *Residents' Guide to People with Chronic Mental Illness.* Washington, DC: American Psychiatric Press; 1993.

   Perhaps the most easily accessible and broadly useful discussion of working with those with chronic mental illnesses. Aimed at medical students and new psychiatric residents but should prove useful to anyone interested in gaining a broad understanding of current psychological, pharmacological, and social approaches.

3. Torrey EF. *Surviving Schizophrenia: A Family Manual.* Harper & Row; 1988.

   An extraordinarily thoughtful, detailed book by one of the nation's leading researchers and patient advocates in the field of schizophrenia. Designed for a lay audience, the book is a must read for family members of people with schizophrenia. It covers the entire field, from etiology and treatment to advocacy and legal and ethical dilemmas.

4. Waldinger RJ. *Psychiatry for Medical Students,* Second Edition. Washington, DC: American Psychiatric Press; 1990:79–101.

   Perhaps the most widely used psychiatry text for medical students. A clear and well-organized overview.

5. Weinberger DR (ed). Schizophrenia. In: *American Psychiatric Press Annual Review of Psychiatry*. Tasman A and Goldfinger SM, eds. Washington, DC: American Psychiatric Press; 1991:5–142.

   This comprehensive review covers neurological, anatomical, neurochemical, functional, psychological, genetic, pharmacological, and psychosocial issues in schizophrenia. Written for a somewhat advanced audience.

SECTION 7 AUDIOVISUAL RESOURCES

1. **Back from Madness: The Struggle for Sanity Kenneth Rosenberg (video).** 1996. Follows four patients for one or two years from their arrival at a hospital. It includes archival footage showing how this illness was treated in the past and how it is dealt with today. Schizophrenia is one of four disorders covered.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189, E-mail: psrc@psych.org.

2. **I'm Still Here: The Truth About Schizophrenia.** 1996. Robert Billheimer. This extraordinarily moving documentary film by an Oscar-nominated director provides in-depth interviews with several individuals who have schizophrenia and their families and caregivers, as well as brief comments by many of the nation's experts on this illness.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189, E-mail: psrc@psych.org.

3. **Schizophrenia (three tapes and an instruction manual).** 1995. Concept Media. Narrator, actors, and interviews with family members provide insight into the causation, symptomatology and community response to those with schizophrenia. A fine in-depth teaching tool.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189, E-mail: psrc@psych.org.

SECTION 8 HANDOUTS/OVERHEADS

CRITERIA FOR DIAGNOSING SCHIZOPHRENIA

Criterion A.

Characteristic symptoms: Two or more of the following psychotic symptoms must be present for a significant portion of the time for at least a month:

- 1-delusions
- 2-hallucinations
- 3-disorganized speech (e.g., frequent derailments or incoherence)
- 4-grossly disorganized or catatonic behavior
- 5-negative symptoms such as affective flattening, alogia, or avolition
- Two of the following: other prominent hallucinations, incoherent or loose associations, catatonic behavior, delusions, flat or grossly inappropriate affect

Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts or two or more people conversing with each other.

- For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset.
- Signs of the disturbance have continued for at least six months, including at least one week of active symptoms (untreated), as described above.
- An organic factor cannot be established as initiating and maintaining the disturbance.
- Mood disorder with psychotic features and schizoaffective disorder are ruled out.
- If there is a history of autistic disorder, prominent delusions and hallucinations must also be present.

PREVALENCE OF SCHIZOPHRENIA

General population, 1%

Sibling of a schizophrenic individual, 7 –9%

Child with one schizophrenic parent, 11 –13%

Dizygotic twin of a schizophrenic individual, 12%

Offspring of two schizophrenic individuals, 40%

Identical twin of a schizophrenic individual, 47%

SUBTOPIC 2

RECOGNIZING AND ADDRESSING DEPRESSION

TIMELINE (60 minutes)

5 min	Introduction
5 min	Review of Objectives
10 min	Overview
35 min	Case Review/Questions
5 min	Additional Questions

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners/trainees, nurses, physician assistants/trainees, mental health workers, and other health professionals.

By the end of this discussion, participants should:

1. Identify the spectrum of affective disorders differentiate major depressive disorder (MDD) from other affective illness

2. Identify the prominent symptoms and signs of MDD

3. Identify medical conditions that can produce symptoms similar to those of MDD

4. Review the variety of treatments used for MDD and some of the barriers to accessing treatment

SECTION 2 OVERVIEW

Epidemiology studies indicate that major depressive disorder (MDD) is a serious and common condition. It is estimated that 2 to 3 percent of men and 4 to 9 per cent of women in the United States suffer from a major depression at any given time. The lifetime risk is thought to be about 10 percent for men and 25 percent for women.

A person may develop the first episode of MDD in childhood, but most commonly it occurs in individuals' twenties. More than half of all patients with MDD will have more than one episode in their lives; some patients have a lifetime of recurrences.

Given that people with MDD are likely to have major disruptions in work and relationships and are likely to feel the future is hopeless, it is not surprising that about half of all suicides in the United States suffer from MDD. It is therefore crucial that physicians be able to assess a person's risk of suicide in the context of an episode of depression.

Diagnosis

The defining features of MDD include a persistently and prominently depressed or sad mood. Patients also experience a loss of pleasure or interest in activities (work, hobbies, sex), which is associated with disturbances in neurovegetative symptoms—sleeping, eating, and energy. They may experience hopelessness, helplessness, worthlessness, or excessive guilt. They often complain of poor concentration and may report thoughts of suicide. They may appear slowed down in their speech and movements (or at times more anxious and edgy), may make poor eye contact, and may be tearful and distressed.

In diagnosing MDD, bear in mind that for a mood state to be considered part of a disorder, it must have distinctive psychological and physiological characteristics. Also, it must be of sufficient intensity and duration to affect ability to function. The Diagnostic and Statistical Manual of the American Psychiatric Association defines major depression as a period of at least two weeks that is a change from previous functioning, where depressed mood and/or loss of interest in activities is coupled with five of the symptoms noted above.

The spectrum of affective (mood) illnesses includes a condition known as dysthymia (from the Greek dys—bad, thymia—mood), which is thought to represent a milder and more chronic variation of major depressive disorder. Dysthymia typically lasts for years and may be difficult to distinguish from a personality trait.

Other relevant conditions include cyclothymia and bipolar illness (also known as manic depressive disorder). Patients with bipolar illness have an elevated state of arousal and an expansive or irritable mood associated with such features as pressured speech, decreased need for sleep, and grandiosity. Cyclothymia (circling moods) is a milder and more chronic condition.

When evaluating a patient you believe may have major depressive disorder, it is important to get an accurate history for symptoms of bipolar affective disorder, as patients with MDD may become manic if treated with only antidepressants. It cannot be known which patients with MDD will have a bipolar risk, although there is some evidence that when bipolar patients are depressed they usually sleep more and eat more (so-called "atypical depression"), in contrast to the more classic symptoms described above for MDD.

Finally, it is important to assess whether a patient is suffering from psychosis. About 10 to 20 percent of patients with MDD can become psychotic. The psychosis typically involves delusions with despairing content (e.g., "My insides are rotting. I am sentenced to death for my sins.") but may involve hallucinations.

Any one of these additional diagnoses would radically alter your treatment plan.

Treatment

Treatment of MDD has been shown to be most effective when both psychological and biological aspects are addressed. Only the mildest of depressions can be treated without medications, and treating MDD with medication alone may miss environmental factors that require attention.

Psychotherapy can focus on cognitive, interpersonal, or psychodynamic issues. Cognitive therapy focuses on thinking patterns that lead to sad feelings. It is demonstrated to be effective in MDD. Interpersonal and dynamic psychotherapies address relationships (present as well as past) that could contribute to the depression.

Response to medication and psychotherapy is in the 70 to 80 percent range for MDD without manic or psychotic features. More severe versions of MDD require referral to a psychiatrist. Shock therapy (electroconvulsive therapy or ECT) remains a relatively safe and important treatment for patients who have psychotic symptoms as part of a MDD.

The Clinician's Role

For the primary care clinician, maintaining a supportive, trusting relationship is a key aspect of successful treatment and medication compliance. A good relationship may also help patients overcome shame they may feel for being treated for a mental disorder.

The primary care clinician must be able to recognize when a person requires referral to a mental health professional (when the patient has manic or psychotic features, when there are family issues, or when suicidal ideation is prominent). In cases of mild to moderate MDD, the primary care clinician may be able to treat the person with antidepressant agents with consultation from the mental health clinician. In addition, in cases where the person with MDD fails to respond to treatment or has an inadequate response, the mental health clinician will be able to evaluate the individual and help tailor treatment to the patient's needs.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Sarah B. is a 41-year-old homemaker who has recently separated from her husband, a carpenter. She reports that she has had headaches for several weeks. Her energy level is extremely low, she has lost her appetite recently, and she is wondering whether she has cancer: "I have just been so down in the dumps."

You were scheduled to see her in two weeks to follow up on her two medical conditions, asthma and thyroiditis. She currently uses an inhaler and prednisone, after an asthmatic flare-up. You discontinued her synthroid after her thyroid function studies normalized six months ago.

When you ask Sarah to tell you more, she reports that she "doesn't want to talk about it too much" and appears overwhelmed by the prospect of trying to explain the problem in detail. You recall that the last time her thyroid function studies were abnormal, she had a similar presentation, but you do not remember any problems with her appetite in the past. You also recall that this patient became very depressed after the birth of her twins five years ago and needed psychiatric hospitalization at that time, after a suicide attempt.

Today she reports that "I wish I could fall asleep and not wake up. I just feel hopeless."

1. What would your next response be?

2. How would you assess this patient's suicidal thoughts?

3. Identify four plausible medical causes for this patient's condition. What psychiatric conditions associated with depression should you be assessing as well?

4. What pieces of information in the history or cues given would help you identify if the patient has major depression? What additional information do you need?

5. Outline the major aspects of a treatment plan.

6. What barriers to treatment may exist for this patient?

SECTION 4 SUGGESTED ANSWERS

1. *What would your next response be?*

Demonstrate empathy and continue to gather data. "You seem to be hurting" is a nonjudgmental display of understanding. "Let's work together to find out the best way to help you" is another.

Denying the patient's experience ("You don't mean that," or "Don't say that") serves only the clinician's anxiety to make this problem go away.

Assessing someone who is voicing suicidal ideation is extremely difficult, and without open communication between patient and doctor, vital information will be lost.

2. *How would you assess this patient's suicidal thoughts?*

The most important issue that must be assessed today is the patient's safety. Sarah has recently reported passive suicidal ideation (the wish never to wake up) and has required hospitalization in the past for a probable post-partum depression with a suicide attempt.

You must obtain a variety of historical information today to determine whether the patient:

- Has an active wish to be dead, has intent, and has a plan that is lethal
- Has ever attempted suicide (and how serious the attempt was)
- Has a family history of suicide
- Has lost her sense of the future or given away her material possessions
- Is using alcohol or drugs
- Feels hopeless
- Is psychotic

If positive responses are obtained, these factors can increase her risk. One factor that is not mentioned is that of gender. As a woman, Sarah has a lower risk of completed suicide (statistically) than a man; however, women are more likely to attempt suicide. The following factors can affect her risk:

- Religious orientation (some religions consider suicide a serious sin; others may have support groups)
- Support system, including family and community
- Additional symptoms from the DSM-III SIGECAPS mnemonic, including appetite or weight changes, guilty or hopeless feelings, and concentration concerns—these may help establish the intensity of the symptoms
- Trusting relationship with her health care provider

• Orientation toward the future

Finally, you should try to obtain the patient's treatment history from her past hospitalization.

The mental status exam is crucial to determine the patient's level of psychomotor retardation or agitation, the degree to which her speech is slowed, and whether she manifests any evidence of psychosis, such as delusional thinking or hallucinations. You must pursue her suicidal thoughts (in terms of ideation, plan, and intent) in order to inform your treatment plan and immediate disposition.

The judgment you will have to make will include the level of care the patient requires (hospitalization, day treatment, or outpatient) and the therapies required.

Each state has different criteria for committing someone involuntarily to a hospital for a brief (usually several days) evaluation and observation. You should know the criteria in your state.

Making this kind of judgment requires knowledge, sensitivity, and experience. If you are unsure how to proceed, obtain consultation from a psychiatrist.

3. *Identify four plausible medical causes for this patient's condition. What psychiatric conditions associated with depression should you be assessing as well?*

A systematic way of thinking about the medical causes of any psychiatric disturbance may be found in the mnemonic MINT: metabolic, infectious, neurologic, and traumatic—and substance-induced.

Metabolic—This patient is taking steroids, a common iatrogenic cause of depression and mania. Checking the onset of her difficulties and the time she started taking prednisone may be fruitful.

Her thyroiditis, an autoimmune condition, can quickly result in weight gain, a decrease in energy, and increased somnolence. Checking her thyroid function tests would be worthwhile.

Infectious—There is no known history, but depression is a common presenting complaint for HIV infection, Lyme disease, and a variety of other conditions.

Neurologic—Recurrent headaches raise a wide neurologic differential diagnosis, including brain tumor and migraines. A careful neurologic exam and more history will be useful.

Traumatic—There is no reported history of recent head injury, but this information should be elicited, as patients may have mental status changes following a subdural hematoma.

Substance Abuse—Although there is no history of substance abuse, depression is a common presentation of alcohol and sedative/hypnotic abuse as well as psychostimulant withdrawal.

Once medical conditions are ruled out, it is useful to probe the psychiatric condition more fully. If this patient has a major depression, it is important to learn if she has had a history of manic episodes (periods of increased energy, impulsiveness, sleeplessness, and grandiosity that may severely impair functioning). If she has, giving this patient an antidepressant alone may improve her depression but facilitate a manic episode.

Also, it is important to discern whether the patient has any psychotic features (loss of reality testing as manifested by delusions, hallucinations, and ideas of reference). These may radically alter the level of care the patient may require, as well as the medication you will prescribe. Post-partum depression is unlikely, given the time course and clinical picture.

4. *What pieces of information in the history or cues given would help you identify if the patient has major depression? What additional information do you need?*

Referring to the DSM-III SIGECAPS mnemonic, this patient manifests appetite disturbance, decrease in energy, suicidal thinking, and guilty (or hopeless) feelings. Her symptoms have lasted for about a month (see Handout 1).

You should ask her about sleep disturbance, concentration problems, and loss of interest in pleasurable activities. Notice whether she appears psychomotor retarded or agitated (posture, level of activity, and speech are all part of this evaluation). You also need to assess her potential for suicide.

5. *Outline the major aspects of a treatment plan.*

Treatments for major depression emphasize each facet of the biopsychosocial aspects of psychiatric disturbance.

Biologically, this patient manifests certain symptoms that require somatic intervention. For instance, the symptoms of sleep, appetite, and lack of energy most typically respond to a variety of antidepressants. Referral to a psychiatrist is advisable when a patient has manic, psychotic, or self-injurious features.

Medication therapy for depression is continually advancing, and research is being done to clarify what subtypes of depression respond better to which medications. Consultation with a psychiatrist is highly recommended before prescribing medications for depression.

If this patient has features of mania (such as increased energy, rapid speech, and flight of ideas), the addition of lithium may be indicated. If the patient's major depressive disorder includes psychotic features (which is an unusual and serious consequence of major depressive disorder), an antipsychotic medication or ECT (also called shock therapy) may be required. Remember that as a depressed and lethargic patient becomes activated by somatic treatments, you must beware of an increased risk for suicide.

Psychologically, this person could be suffering from a number of stressors. A conscientious and supportive physician may be enough to aid this woman through the experience, but she also may require more specialized intervention. Psychotherapy can be directed in a supportive manner, helping this patient to mobilize useful resources around her. Therapy also can be used to help elicit any cognitive distortions that may be ensuing from this depression and to help the patient understand if there are interpersonal reasons for her suffering.

Asking about family and community supports is crucial to mobilizing the resources this patient may need to continue treatment. If she and her husband are having difficulties, the problem should be addressed, perhaps in couple therapy. The clinician should consider what arrangement the children will have and what risks they may be under while this woman is suffering from a serious psychiatric disorder. Finally, if the patient finds it helpful to relate to other people in similar circumstances, group psychotherapy may be indicated.

6. *What barriers to treatment may exist for this patient?*

It is very common for people who are suffering from psychiatric disorders to lose the ability to observe themselves and have what clinicians call a "deficit in insight." This patient is presenting for what she believes are somatically related concerns, and there is good evidence to suggest that patients who are depressed present commonly to primary care physicians. You should be very supportive when telling patients they probably have a psychiatric disorder. Explaining that depression is a chemical imbalance in the brain is often helpful and can decrease the stigma attached to mental illness by medicalizing the pathophysiology.

Some people believe that to seek help for depression is a sign of weakness or a moral failing. Others feel guilty and bewildered by their depression, especially in the absence of any acute or chronic stressors. If this patient were of a different culture, it would be incumbent upon you to have some understanding of how that culture comprehends depression and views psychiatric disorders. Then you should ask yourself the following questions:

- Have you made an effort to work with the patient's support system?
- Have you explored ways in which the patient's extended family may be exacerbating or promoting the symptoms?

- If there is a language barrier, how will you address it?

SECTION 5 ADDITIONAL EXERCISES

1. Many clinicians (the first was Freud) have compared and contrasted major depression and bereavement. Discuss your experience of a significant loss of a person in your life. What helped you during the aftermath of the loss?

2. Debate the reasons that women are at greater risk of experiencing major depression. How do you think the following factors are involved: cultural norms, oppression, biological predisposition?

SECTION 6 SUGGESTED READING

1. *Clinical Practice Guideline Number 5. Depression in Primary Care: Detection, Diagnosis, and Treatment.* Washington, DC: US Department of Health and Human Services; 1993.

   An excellent and thorough publication designed for primary care clinicians. Volume 1 covers detection and diagnosis. Volume 2 addresses treatment.

2. *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R). Washington, DC: American Psychiatric Press; 1987.

   The classic diagnostic manual for psychiatric disorders. Especially note sections on major depression, dysthymia, bipolar affective disorder, and cyclothymia.

3. Kocsis J, ed. Dysthymia and chronic depression states. *Psychiatric Annals*. 1993;23:11.

   Discusses relevant aspects of chronic depression states, including co-morbidity and treatment.

4. Waldinger RJ. *Psychiatry for Medical Students*, Second Edition. Washington, DC: American Psychiatric Press; 1990.

   This commonly used text is straightforward and user-friendly. The chapters on suicide and major depression are well-written and easy to follow.

5. Zisook MD, ed. Grief and bereavement. *Psychiatric Clinics of North America*. 1987;10:3.

   An excellent overview of human response to loss. Compares and contrasts bereavement and depression.

SECTION 7 AUDIOVISUAL RESOURCES

1. **Depression: Diagnosis and Treatment.** 1989. This solid overview of the field of depression includes a good discussion of atypical depression, which was not covered in this module. Four audiotape set and manual on the following topics: Introduction, Atypical Depression, Depression and Personality Disorders, Depression and Suicide.

   Contact: Guilford Publications, 72 Spring Street, New York, NY 10012. 800-365-7006. $50 rental. Catalogue no. 2956.

2. **Depression: Feeling Good Again.** 1988. Sehon Buchanan Medical Media. A good basic teaching tape that includes interviews with patients and psychiatrists, with topics ranging from mourning through disabling disorders and suicidality.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

3. **The Mind: Depression.** 1988. Part of the Public Broadcasting Service series on the mind, this tape includes interviews with doctors and patients who discuss their responses to, and experiences with, depressive illnesses. Treatment with medication and ECT are covered.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

SECTION 8 HANDOUT/OVERHEAD

SYMPTOMS OF DEPRESSION

S Suicidal thinking
I Loss of interest
G Guilty or hopeless feelings
E Decrease in energy
C Concentration problems
A Appetite disturbance
P Psychomotor retardation or agitation
S Sleep disturbance

Handout 1

SUBTOPIC 3

FEELINGS ABOUT MENTAL ILLNESS

TIMELINE (60 minutes)

10 min	Purpose and Format of Module
10 min	Ice Breaker
40 min	Experiential Exercises

SECTION 1 LEARNING OBJECTIVES

Target Group: Anyone practicing in the physical or mental health services or contemplating a health service career.

By the end of this discussion, participants should:

1. Explore their feelings about mental illness and the mentally ill

2. Talk about mental illness with each other, with patients, and with patients' families

NOTE TO FACILITATORS

Rather than attempting to impart a body of knowledge, this session explores participants' feelings about mental illness and the mentally ill. After a brief overview, several exercises are suggested. There are no correct answers. Instead, further questions and possible approaches are offered.

This module will require flexibility on your part and a willingness to follow the group's feelings and interactions as they lead in potentially unpredictable directions. Familiarity with mental illness and with some of the films, books, or personal experiences mentioned is helpful but not essential. Most critical is your ability to reflect on your own experiences in this area and to set the tone of the session by sharing some of these with the group.

Feel free to use a more structured approach with film sequences that depict powerful images of mental illness. This technique may create an environment in which people can more easily discuss their experiences. Your comfort with directing group discussions about sensitive topics may also determine whether to use the film clips or the open-ended approaches of Exercises 3, 4 and 5. The open-ended approach is recommended only for experienced group leaders.

Because of the experiential and somewhat intimate nature of this session, you should explore the degree to which the group would feel more comfortable if the things they say in the meeting are held confidential. Initially and shortly before wrap-up, you should make statements about respecting what has been shared and reinforcing those who have been open with their experiences.

In groups that do not quickly take up discussion, it may be best to use an example from your own life to get the discussion going. In groups where responses become overly detailed, personalized, or appear to be the result of profound and critical issues (for example, a member who has been psychiatrically hospitalized), the most appropriate tactic may be to move from the specific to the general after gaining the approval of the at-risk individual.

It will be very important to summarize and normalize the spectrum of group responses to the mentally ill, as these are emblematic of society's larger spectrum of beliefs. This module's most important lesson is that understanding one's attitudes and feelings toward the mentally ill is an important endeavor for health professionals. Providing an opportunity for people to talk about what it was like for them to be in the group may also be a way to help them debrief after becoming involved in what could be an emotionally taxing discussion.

Possible closing comments might include: "It's often hard to talk about personal feelings, especially those we consider irrational or dislike having. I think you've been reflective and honest, and I'm glad you've taken the opportunity to share with the group. I know I've learned from this experience, and I hope you've gained increased understanding of yourselves and your feelings."

SECTION 2 ICE BREAKER

Hand out the Mental Illness Quiz (see Handouts section), and ask participants to fill them out and keep them. Provide answers as opportunities arise during the session.

SECTION 3 EXPERIENTIAL EXERCISES

1. Watch brief segments from one or two movies in which mentally ill individuals play a key role.

   - How are these people portrayed?
   - What emotions do the characters evoke in you?
   - What aspect of the film made you feel this way?

2. Think about a book you have read in which one of the central characters suffers from a mental illness.

   - Describe it briefly.
   - Talk about your experience while reading it.

3. It is difficult to think about how disturbing the internal world of people who suffer from mental illnesses can be. Ask the group to think about experiences they have had that may resemble the experiences of individuals with severe and persistent mental illness.

4. Have you had an occasion to observe or interact with somebody with serious mental illness? Was this in a clinical setting or in the outside world? How well did you know the person? If you knew the person before the mental illness, in what ways had he or she changed?

5. Have you ever told someone that a member of his or her family has a fatal illness? What feelings did this evoke? Imagine telling someone that a family member has schizophrenia. In what ways would this be similar to talking about a fatal illness? In what ways is it different?

SECTION 4 SUGGESTED DISCUSSION APPROACHES

1. *Watch brief segments from one or two movies in which mentally ill individuals play a key role.*

   How are these people portrayed?

   Generally, mentally ill individuals are portrayed unsympathetically. Movies that are likely to be mentioned may include "One Flew over the Cuckoo's Nest," "Psycho," "Ordinary People," "Prince of Tides," "Titticut Follies," "Equus," "Nuts," and "Silence of the Lambs."

   What emotions do the characters evoke in you?

   In many of these films, the mentally ill individual evokes fear, horror, and loathing. Some of the more sympathetic portrayals may evoke concern, sympathy, compassion, and, in rare cases, identification.

   What aspect of the film made you feel this way?

   Usually the worlds of the mentally ill are portrayed as irrational, incomprehensible, isolated, and frightening. Portrayals are frequently dehumanizing, emphasizing the individual's difference from "normal" people rather than fundamental similarities.

   Although many movies capitalize on fantasies of the mentally ill as dangerous and maniacal, it is the movies that focus on characteristics similar to all of us that we find most disquieting.

2. *Think about a book you have read in which one of the central characters suffers from a mental illness.*

   Likely choices may include *One Flew over the Cuckoo's Nest* by Ken Kesey, *I Never Promised You a Rose Garden* by Joanne Greenberg, *The Eden Express* by Mark Vonnegut, *Silence of the Lambs* by Thomas Harris, *Sybil* by Flora Rheta Schreiber, any of the popular mysteries by psychologist Jonathan Kellerman, or various horror stories.

   As in the exercise above, these can be used as a jumping-off point to discuss the techniques used by authors to distance us from the internal world of mentally ill individuals. It may be useful to contrast books written by people with mental illness or their therapists (e.g., *The Eden Express* or *I Never Promised You a Rose Garden*) with those written by others.

You may want to discuss why people are fearful of mental illness. Three basic themes generally emerge. One is that to have a mental illness in our society is to become stigmatized. As people become more educated about mental illness, they begin to understand that it can be ordered and categorized, and it begins to appear less overwhelming.

Second, people like to believe they are in control of their lives and their mental processes. Because mental illness assaults this notion of control, it can be devastating and terrifying. Similar views are held toward conditions such as Alzheimer's disease.

Finally, mental illness often inspires a sense of helplessness in people who attempt to treat it. Health care professionals tend to fear what is difficult to treat and understand. This is why health care providers must be encouraged to discuss their attitudes and experiences about mental illness.

3. *It is difficult to think about how disturbing the internal world of people who suffer from mental illnesses can be. Ask the group to think about experiences they have had that may resemble the experiences of individuals with severe and persistent mental illness.*

   Examples shared by the group may involve feelings of alienation, disorientation, or being misunderstood. Possible responses and issues to highlight include:

   - Spending time in a foreign country where no one speaks your language. Underscore the sense of being misunderstood, of being unable to have your needs met, of misinterpreting cultural cues and events around you, of realizing you may need help and are unable to get it.
   - Drug-related experiences. These may be difficult to evoke and uncomfortable to handle in a group setting. One approach might be to have the group silently think about times when they may have used drugs or alcohol to excess. They should think about how their ability to express themselves may have been impaired, how their perceptions of reality altered, and how cues about time and spatial perception were altered. How might it feel to have these experiences in an ongoing way, coming and going without your control? How might they affect your ability to take part in activities with other human beings? How does thinking about these states make you feel?
   - Hypnopompic experiences (feelings of disorientation upon awakening from sleep). Ask the group to discuss dreaming as a mental status phenomenon. Do discussants know they are dreaming sometimes? How might this be similar and different from experiencing a psychotic process?

4. *Have you had an occasion to observe or interact with somebody with serious mental illness? Was this in a clinical setting or in the outside world? How well did you know the person? If you knew the person before the mental illness, in what ways had he or she changed?*

Examples are likely to come from three categories: clinical settings, casual interactions, and personal experiences. Most people who encounter seriously mentally ill people "in the outside world" feel a mix of fear, concern, confusion, and perhaps contempt. If possible, talk about how being panhandled by an obviously mentally ill homeless individual made participants feel.

In clinical settings, health professionals tend to respond to mental illness in a much more dispassionate way. If members of the group have completed rotations on psychiatric services, ask them to compare their feelings about patients they talked with in a hospital or outpatient setting to the feelings they experienced with those outside of such settings. How do they account for their altered response? Concerns about safety, of greater understanding in the clinical setting, of familiarity and its relationship with compassion, and of differing issues when one feels responsible for another individual can be highlighted.

If somebody in the group has a close friend or family member who suffers from mental illness, gently ask if that group member would be willing to talk about the experience. How has the nearness of mental illness to their lives affected them? If no one shares such an experience, ask if anyone knows someone who has attempted or committed suicide? Do they think about severe depression as a mental illness? If not, why not?

5. *Have you ever told someone that a member of his or her family has a fatal illness? What feelings did this evoke? Imagine telling someone that a family member has schizophrenia. In what ways would this be similar to talking about a fatal illness? In what ways is it different?*

Discomfort, anxiety, embarrassment, and sympathy are likely to be part of the discussion for both situations. Possible areas to explore include: feelings about mortality versus impairment; family responsibility for "causing" mental illness; and discomfort over diagnosing disorders with which the group members are relatively unfamiliar.

Certainly, helplessness is a part of professional response to either of these illnesses. However, mortality is a part of everyone's life; "madness" may be seen as a particularly horrible and unexpected disorder.

A related exercise might involve a role-play. Have one participant play a parent whose sibling was diagnosed with cancer. Have a second participant draw on medical expertise to help explain the illness to the parent. Now do the same exercise where the diagnosis is schizophrenia.

SECTION 5 SUGGESTED READING

1. Fink P, Tasman A (eds). *Stigma and Mental Illness.* Washington, DC: American Psychiatric Press; 1992.

   Documents the issues surrounding personal and societal responses to those suffering from psychiatric disorders. In a series of vignettes, many of the major dimensions of stigma are addressed.

2. Media and mental illness. *Journal of the California Alliance for the Mentally Ill.* 1993;4.

   This thought-provoking publication by an advocacy group in Los Angeles is a collection of articles about how severe mental illness has been treated by Hollywood.

3. Sechehayem. *Autobiography of a Schizophrenic Girl.* New York: Greene & Stratton; 1953.

   Probably the best written account of what it is like to have schizophrenia. Translated from the French, this is a moving and dramatic book. The second part, which uses somewhat outdated interpretations of the author's symptoms, is not recommended.

4. Sheehan S. *Is There No Place on Earth for Me?* Boston: Houghton-Mifflin; 1982.

   This deservedly famous book is a heartbreaking account by a journalist of the life of Sylvia Frumkin and her deterioration from an intellectually gifted student to a "lost soul" on the streets of New York City. It will change your view of chronic mental illness forever.

5. Torrey EF. *Surviving Schizophrenia: A Family Manual.* Harper & Row; 1988.

   This is an extraordinarily thoughtful, well-detailed book by one of the nation's leading researchers and patient advocates in the field of schizophrenia. It is a must for people with schizophrenic family members. Covering the entire field, from etiology and treatment to advocacy and legal and ethical dilemmas, the book includes extensive quotations from individuals.

SECTION 6 AUDIOVISUAL RESOURCES

1. **Coping with the Stigma of Mental Illness.** 1996. Carter Center. This documentary was filmed at a meeting hosted by former First Lady Rosalynn Carter and features actor Rod Steiger and author Kathy Cronkite discussing their personal experiences with mental illness.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

2. **Through Madness: The Subjective Experience of Mental Illness.** 1992. Kenneth Rosenberg. Through interviews with individuals with severe mental illnesses, the film captures incredibly moving descriptions of the life-altering problems each of these men and women face. Lionel, a former NFL Green Bay Packer, and a well-known patient advocate are featured.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

SECTION 7 HANDOUTS/OVERHEADS

MENTAL ILLNESS QUIZ

1. In an average week, most people observe more mentally ill people on television than in real life.

   True False

2. On television, the mentally ill are more likely to be treated as violent than are their non-ill peers.

   True False

3. On television, the mentally ill are more likely to be victims of violence than are their non-ill peers.

   True False

4. Psychiatric patients who have little use of criminality prior to hospitalization are more likely to become criminals after being hospitalized.

   True False

5. Lunacy, the term derived from the notion that the moon has influence on the psyche, is well-supported by the medical literature.

   True False

6. Demographically, the group most opposed to psychiatric halfway houses is property-owning males.

   True False

7. Abraham Lincoln and Winston Churchill are thought to have had diagnosable psychiatric disorders.

   True False

ANSWERS TO MENTAL ILLNESS QUIZ

1. True
2. True
3. True
4. False
5. False
6. True
7. True

SUBTOPIC 4

PANIC DISORDER AND POST-TRAUMATIC STRESS DISORDER

TIMELINE (60 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives
10 min	Overview
35 min	Review of Case/Questions
5 min	Additional Questions

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners/trainees, nurses, physician assistants/trainees, mental health workers, and other health professionals.

By the end of this discussion, participants should:

1. Identify panic disorder and post-traumatic stress disorder

2. Discuss aspects of treatment for panic disorder and post-traumatic stress disorder

3. Discuss some of the controversy around extending the concept of traumatic experience to personality development (e.g., child abuse) and to other syndromes involving chronic events (e.g., the "battered wife syndrome")

SECTION 2 OVERVIEW

A large epidemiologic study revealed that anxiety disorders are the most prevalent psychiatric disorders in the United States. The majority of patients who suffer from anxiety disorders receive care in primary care settings. Commonly, they present with what they believe are somatic syndromes (e.g., a heart attack).

Panic disorder is the best understood of the anxiety disorders. Post-traumatic stress disorder (PTSD) is a clinically relevant syndrome.

Panic Disorder

The diagnosis of panic disorder is made when a patient experiences episodes of intensive anxiety that begin suddenly and then quickly become severe. This syndrome manifests a variety of somatic concerns, such as tachycardia, chest pain, shortness of breath, sweating, and nausea. Patients often mimic symptoms of cardiac events. They may present with a fear of "going crazy" or dying in association with these symptoms.

Panic disorder patients commonly have other comorbid problems, such as agoraphobia (a fear of open spaces). Such individuals may restrict their activity more and more and eventually become housebound. Panic disorder patients may also self-medicate with alcohol or other substances. Many manifest major depressive disorder.

It is important to recognize that patients with panic disorder can have medical illness in addition to their panic symptoms. There is some evidence, for example, that patients with panic disorder have a somewhat higher incidence of mitral valve prolapse.

A careful history for caffeine intake, amphetamine or cocaine use, and alcohol or other sedative withdrawal should be taken in any patient who presents with serious anxiety and/or panic attack, as these substances can mimic panic symptoms. Additionally, hyperthyroidism should be considered.

Panic disorder patients require a supportive and trusting relationship with their clinician. Clinicians can offer behavioral interventions, including techniques to lessen anticipatory anxiety or maximize coping strategies during a panic attack. For patients who restrict their mobility because of fear of panic attacks, behavioral work can be very effective. Consultation with a person who has specific training in this area is essential.

Patients with panic disorder respond fairly well to medication. Antidepressants have been found to be relatively effective but have a delayed onset of action. Benzodiazepines have been used in a short-term manner to control the immediate symptoms of panic. All patients who use benzodiazepines should be carefully evaluated for the risk of becoming dependent on these

medications. In fact, benzodiazepines may not be appropriate for many patients, especially those with histories of substance abuse.

According to some studies, once control of panic attacks has been achieved with medication, behavioral therapy can be employed to even greater effect. There is no clear consensus on how long a patient should be on medication for panic. This is a decision that probably should be managed by consultation with or referral to a psychiatrist.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) occurs among people who have experienced traumatic events such as combat, torture, rape, natural disasters, and accidents. Persons with classic PTSD report three classes of experience following the trauma.

First, they relive the traumatic experience through nightmares or intrusive recollections. Second, they experience "psychic numbing"—detachment from others and inability to recall an important aspect of the trauma. Third, they exhibit an increased autonomic arousal. For example, they may have outbursts of anger, difficulty concentrating, and a heightened startle response.

People with full PTSD commonly report anxiety and depression symptoms. Substance abuse is a common symptom; it may represent an effort to modulate the strong feelings that are central to this diagnosis.

Historically, clinicians first viewed PTSD responses primarily as acute and time-limited. The 1970s brought a great deal of interest to this phenomenon, as thousands of Vietnam veterans reported PTSD symptoms. In 1980 the DSM-III introduced PTSD as a diagnostic entity. The disorder included a chronic reaction to trauma and allowed for premorbid and concurrent pathology.

Prevalence and incidence may vary widely, depending on the events in a given area. One study found that classic PTSD was relatively uncommon, with a prevalence around 1 percent. Prevalence increased to about 3.5 percent for citizens exposed to physical attack and 20 percent for Vietnam veterans not wounded in combat. No differences in age, sex, or race are found. Disorders concomitant with PTSD include obsessive compulsive disorder, manic depressive illness, and dysthymia.

Not all people who experience a traumatic event will suffer from classic PTSD. Two factors are involved—the nature of the stressor and the nature of the patient. The stressor must be extreme and must involve intense fear, helplessness, or loss of control. Also, the incidence of PTSD directly correlates with proximity to a traumatic event. For example, person A, who is shot at close range, is more likely to develop PTSD than person B, who witnesses a shooting at 200 feet.

It is possible that there is a genetic predisposition to developing a severe response to trauma. Also, exposure to prior traumatic events may increase the risk that a person will develop PTSD.

Some speculate on pre-existing personality as a factor. Finally, people who have a strong support system in place after a traumatic event have a much better chance of weathering the aftermath without developing PTSD.

Clinicians believe that the treatment of PTSD requires attention to each aspect of the biopsychosocial model. Most researchers agree that a therapeutic relationship, group therapy, attention to the patient's culture and supports, and medications each offer value. One common challenge occurs in facilitating a therapeutic alliance with someone who has had some aspect of trust broken by a traumatic event. Group therapy can decrease the sense of isolation, shame, and survivor guilt that many people report.

The pharmacologic treatment of PTSD is a growing field, but no controlled studies have been done. One model proposes that the locus ceruleus has something to do with the symptoms; medication that blocks the norepinephrine or noradrengergic system might be useful.

Clonidine has been reported to be effective. Beta-blockers also have been used to decrease sympathetic arousal. Benzodiazepines have been reported to improve sleep and decrease nightmares. Tricyclic antidepressants are used widely and have been repeatedly judged most effective for nightmares and other intrusive symptoms. Lithium and carbamazepine also have been used.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Thomas Johnson, a 25-year-old man, comes to your emergency room clutching his chest and claiming he is having a heart attack. He is grossly diaphoretic, and his skin is quite flushed. His pulse is 130, and he is having difficulty with respiration.

You begin an IV, get an ECG and draw blood for laboratory analyses to rule out a myocardial infarction. When you ask the patient about his history, he has difficulty reporting, because he appears so overwhelmed. In time you are able to help him calm down, and you learn that he has not had chest pain but rather had an extreme sense of palpitations that began shortly after he began driving his pickup truck. He quickly became overwhelmed by the sensation, pulled off to the side of the road, and found his heart beating so fast he was certain he was going to die.

You also learn that he has been drinking approximately a six-pack of alcohol a day for the last six months. The patient mentions that he killed two pedestrians in this truck approximately six months ago and was feeling "shaky" for the last six months but had never experienced anything of this sort.

1. The ECG is normal except for tachycardia. All blood studies, including cardiac enzymes, are normal, with the exception of a blood alcohol level of 1.4 (meq/L). What is the psychiatric differential diagnosis now that the cardiac condition has been ruled out?

2. If you believe this patient may have had the first episode of a post-traumatic syndrome, what other historical questions would you need to pursue to learn if he has the full syndrome of post-traumatic stress disorder?

3. How do you understand this patient's alcohol intake in relation to his symptoms?

SECTION 4 SUGGESTED ANSWERS

1. *The ECG is normal except for tachycardia. All blood studies, including cardiac enzymes, are normal, with the exception of a blood alcohol level of 1.4 (meq/L). What is the psychiatric differential diagnosis now that the cardiac condition has been ruled out?*

   This patient, while believing he was suffering from a cardiac condition, is much more likely to be suffering from a serious anxiety disorder. He had a classic presentation for a panic attack that is time-limited. An unexpected period of sympathetic arousal produces a variety of somatic symptoms including palpitations, flushing, shortness of breath, and a sense of doom. Because of this patient's history of exposure to a severe trauma, he may be developing the first symptoms of post-traumatic stress disorder. The effects of alcohol withdrawal will have to be considered as well.

2. *If you believe this patient may have had the first episode of a post-traumatic syndrome, what other historical questions would you need to pursue to learn if he has the full syndrome of post-traumatic stress disorder?*

   This patient should be asked if he has had any of the classic symptoms of post-traumatic stress disorder. First, has he had any experience of an intrusive nature, e.g., flashbacks, daydreams, or nightmares that are specific to the trauma or things associated with it? The association of his panic-like symptomatology while entering the truck he was driving when the tragedy occurred is extremely common.

   Second, has he had felt numb, "cut off," or "dead" emotionally? This is an extremely common response after a traumatic event. Third, has he had any other evidence of sympathetic arousal (e.g., does he startle easily when confronted with a novel stimuli, or does he feel "jumpy" or "wired"?). It is not uncommon for patients with post-traumatic disorders to abuse substances in order to self-medicate their disturbances.

   Panic disorder is a more challenging differential diagnosis for this patient, as he presented with what is almost a classic panic attack. Panic attacks can only be diagnosed when it is clear that medical factors are not responsible for the symptoms (e.g., a thyroid disorder or a pheochromocytoma). Panic attacks are, by definition, initially unexpected, although later they may begin to be associated with the place or circumstances where they first occurred.

   Another differential diagnostic category would be withdrawal from an intoxicating substance or a substance abuse-induced disorder. For instance, amphetamines or high doses of caffeine may create symptoms identical to a panic attack. Similarly, withdrawal from alcohol and barbiturates could also produce a similar sort of episode.

Major depressive disorder also carries with it an increased risk of anxiety, and panic attack is more likely to occur in patients experiencing a major depressive episode than in people who are not depressed.

3. *How do you understand this patient's alcohol intake in relation to his symptoms?*

Research has demonstrated that many people try to self-medicate their symptoms to regulate their emotional state. Because alcohol has some effectiveness as an anti-anxiety agent, it is commonly abused in anxiety disorders. However, alcohol has protean manifestations and numerous side effects. It is a very ineffective anti-anxiety agent in the long term.

Physicians should approach this problem educationally, explaining some of these ideas and also encouraging the patient to get more effective treatment for anxiety than alcohol. Check your state laws for physician reporting obligations for people who drink and drive.

SECTION 5 ADDITIONAL QUESTIONS FOR DISCUSSION

1. What challenges do you think would be faced by a clinician who works with several people in this situation? How might the clinician maximize his or her therapeutic energies?

2. How is this case different from that of a woman, beaten by her husband for years, who presents to your emergency room with suicidal ideation and alcohol abuse? How is it similar?

SECTION 6 SUGGESTED READING

1. Cassem EH. Depression and anxiety secondary to medical illness. *Psychiatric Clinics of North America.* 1990;13(4):597–612.

2. Katon WJ. Chest pain, cardiac disease, and panic disorder. *Journal of Clinical Psychiatry*. 1990;51(Suppl):27–30,50–53.

   A thorough review of the aspect of differentiating cardiac from psychiatric etiologies of symptoms that may present in a similar manner.

3. Silver J, Sandberg D, Hales R. New approaches in the pharmacotherapy of post-traumatic stress disorder. *Journal of Clinical Psychiatry.* 1990;51(Supp):33–38.

   An excellent review of each of the categories of medication explored in the treatment of PTSD. Includes the history of treatment as well as more recent developments in the field.

4. Van der Kolk B. *Psychological Trauma.* Washington, DC: American Psychiatric Press; 1987.

   This well-written book covers the research and clinical aspects of PTSD.

5. The National Institute of Mental Health maintains a resource list to help health care providers obtain information about panic disorder. For a copy, call 800-64-PANIC.

SECTION 7 AUDIOVISUAL RESOURCES

1. **The Panic Prison (28.5 min).** 1991. Silvermine films for the American Psychiatric Association. Dramatic patient descriptions tell how panic attacks terrorize victims into a no-win game of avoidance. Includes treatment methods, support group in progress, and follow up of some successfully treated patients.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org. $75 for medical students. Free loan from district APA branches in states.

2. **Post-Traumatic Stress Disorder.** 1991. Dartmouth Hitchkock Medical Center. The breadth of traumatic experiences that can result in this disorder are demonstrated through interviews with a Vietnam veteran, two survivors of the 1989 San Francisco earthquake, and a woman who is an incest survivor.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

SUBTOPIC 5

PATIENT-CLINICIAN RELATIONSHIPS

TIMELINE (60 minutes)

10 min	Introduction/Ice Breaker
5 min	Overview
40 min	Review of Cases/Questions
5 min	Additional Questions

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners/trainees, nurses, physician assistants/trainees, mental health workers, and other health professionals.

By the end of this discussion, participants should:

1. Identify some of the domains in which boundary violations with patients are most likely
2. Describe some of the common pitfalls clinicians must face in maintaining the integrity of their professional relationships
3. Describe some of the major legal and ethical standards regarding these relationships

SECTION 2 ICE BREAKER

Before approaching the more controversial topics of this session, it might be useful to begin with a question that is less highly charged. For example: "Have you ever treated a patient you felt was, in many ways, just like you, except for an illness? How did working with him or her make you feel compared to how you feel with other patients?"

SECTION 3 OVERVIEW

The national media and the public at large have been increasing their scrutiny of the intrusion of sexuality into doctor-patient relationships. The media have given special emphasis to sexual relationships between psychiatrists and their patients, but data suggest that these relationships occur across all medical specialties.

A number of authors have pointed out that the special nature of the treatment relationship is rarely dealt with in the formal curricula of health care disciplines. While trainees and young professionals have had considerable experience in many other roles (daughters, sons, spouses, patients, parents, etc.), learning how to act like a doctor places new role demands with attendant uncertainty and tension. Often providers respond by using familiar but non-professional roles they are used to, treating a patient like their close friend, their child, their grandparent.

The goal of this session is to open for discussion the potential pitfalls and dilemmas of substituting these familiar roles for more professional ones. Duckworth, Kahn, and Gutheil describe four maturational tasks that must be accomplished in developing appropriate professional role structures, and they identify corresponding interpersonal tensions providers experience:

Maturational Task	*Corresponding Tension*
• Learning to know a patient's pain	• Empathizing without over-identifying
• Preserving equanimity in the face of suffering	• Being objective rather than avoidant
• Being genuinely helpful and effective	• Collaborating rather than coercing
• Maintaining healthy professional self-esteem	• Feeling confident rather than special

A useful approach to this session might be to reflect on how participants' comments reflect these tasks and tensions. The vignettes that follow can be used as a basis for exploration.

SECTION 4 CASE STUDIES

Case 1

Mrs. O'Malley is a 72-year-old woman you have been following for a little over a year. She has multiple medical problems, including severe arthritis, diabetes controlled by oral hypoglycemic medications, a history of bowel obstructions and successfully treated colon cancer, and episodic bouts of moderate depression. You have grown quite fond of Mrs. O'Malley, a charming and interesting widow who lives alone in her old family home. Her three children and multiple grandchildren live in distant states.

Last month, Mrs. O'Malley invited you over for dinner. Having no plans and finding her reminiscences of her early adulthood during World War II quite interesting, you agreed. She was a great cook, and you eagerly accepted her second invitation two weeks later. Last week she called several times, asking what night you were free, but you had out-of-town company and were beginning to feel she was not that interesting as a regular dinner companion. Today, she comes into your office tearful and unhappy. She wonders if her cooking was not to your taste and whether you do not care about her anymore.

Case 2

You have been following Mr. Gorman for about nine months for hypertension. You have increasingly grown to feel that he is the kind of person you could really be friends with if you had the time. A vice president of the local department store, he is bright, funny, self-reflective, and interested in music, rock climbing and squash—some of your favorite activities. Last month, he mentioned a hot stock that his broker had suggested. You bought the stock, which doubled in value during the intervening month.

Last week, your brother (an investment banker) told you about a hot stock tip. In the course of his checkup, Mr. Gorman gloats over how well the stock he mentioned last session had done. You cannot resist telling him that you bought many shares and then telling him about your brother's stock tip.

Case 3

Ms. Woods is a strikingly attractive 23-year-old woman who has being worked up for a self-discovered breast mass. (Feel free to substitute Mr. Sturman, a strikingly handsome man with epigastric pain.) During your frequent contacts in the course of the work-up, your patient shares that she is currently going through a difficult divorce from her spouse of one year. You have just separated from your own spouse, having found that each of you has changed quite a bit since your marriage four years ago.

You admire your patient for her courage and strength in the face of her uncertain diagnosis, and you find her charming and friendly. During a physical exam, your patient begins to talk about how lonely and frightened she feels. In the course of reassuring her, you put your hand on her shoulder and hold her arm. After you schedule the next appointment, your patient invites you over for dinner, stating how much she thinks you would enjoy watching a movie on her new giant screen television.

Case 4

You are evaluating Mr. Johnson, a 58-year-old attorney who comes in for a routine physical while your partner is on extended leave. This patient is a close personal friend of your partner. As you flip through the record, you realize there is almost no documentation, and that your colleague has been seeing this patient on a pro-bono basis.

You are extremely disturbed to realize that this patient, who is obese and a smoker, has never had a proper cardiac work-up. Upon physical exam, you notice a heart murmur and hypertension. You wonder how your colleague's friendship with this patient may have interfered with his ability to do a proper and thorough evaluation.

Case 5

As a cardiologist, you are an avid jogger and a member of the local jogging club. One of your patients, who has recovered from a myocardial infarction and has been doing well on a calcium channel blocker, is on a run with you. During the run, he begins to experience some classic anginal symptoms. You advise him to stop, and when he states that he would like to keep running, you ponder what to do.

Case 6

One of your patients, whom you have suspected of having anorexia nervosa and bulimia for some time, reports that she is on a "starvation diet," and her weight is now down to 88 pounds. You consider her to be only three pounds above her medical limit of safety.

She has told her boyfriend nothing except that she "loves to be skinny." He is in the waiting room, appearing quite anxious, and you wonder about your ability to discuss this matter with him to gain his support in helping your patient.

SECTION 5 DISCUSSION QUESTIONS

There are few rules to guide relationships between clinicians and their patients. The Hippocratic oath provides the general framework from which many of today's legal and ethical stances have developed. This code of ethics, developed by a Greek physician generally regarded as the "Father of Medicine," dates from the late fifth century BC. Its most critical statements include, "I will prescribe regimen for the good of my patients according to my ability and judgment and never do harm to anyone. . . .In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill doing and all seduction."

The ethical codes of the American Medical Association and other health care disciplines expand on Hippocrates' statements and update them for modern practice. However, these guidelines do not specifically address many of the situations in which the modern clinician finds himself or herself.

Rather than attempt to address the issues raised in each case, this session's broad series of questions is designed to elicit participants' feelings and experiences to allow each of the group members to begin developing a personal set of responses to complex clinician-patient relational issues.

1. How is a physician-patient relationship similar to, and different from, a relationship between a merchant and a customer? Between a leader of a religious order and a believer?

2. Do you think your patients act differently toward you than they do toward their parents? Business associates? Lawyers? Spouses? Why?

3. Think about the health care providers whose patient you have been. What factors in their behavior made you feel comforted? Anxious? Angry? Threatened? Safe? What might they have done differently to improve your response? What would have made you feel worse?

4. How do you think seeing your health providers socially would affect your feelings about being their patient?

5. What are some of the values that must be considered in weighing ethical decision-making in medicine?

SECTION 6 SUGGESTED ANSWERS

1. *How is a physician-patient relationship similar to, and different from, a relationship between a merchant and a customer? Between a leader of a religious order and a believer?*

   Issues that might emerge include differences in the nature of the "products" sold by a merchant versus those of a physician, the role of trust, expected professionalism, the necessity of medical care versus consumer products, and the differences in the "expressed" and "implied" warranties provided by each.

   Compared to a religious leader, although confidentiality may be protected in both cases, a physician may be seen as having greater mandates to foster open choice, provide information, and openly discuss the risks and benefits of the interventions offered.

2. *Do you think your patients act differently toward you than they do toward their parents? Business associates? Lawyers? Spouses? Why?*

   These questions should foster discussion of the physician-patient contract, the influence of financial concerns on the relationship, confidentiality, informed consent, professional concern versus personal attraction, and the primacy of the patient's needs. Discussions of hopefulness, aggrandizement, anxiety, guilt, and passivity could also be explored.

   Asking participants how they feel when talking to their parents, other participants, and doctors (and why these feelings may differ) might initiate this discussion.

3. *Think about the health care providers whose patient you have been. What factors in their behavior made you feel comforted? Anxious? Angry? Threatened? Safe? What might they have done to improve your response? What would have made you feel worse?*

   It might be useful to set up two columns on a blackboard: behaviors that resulted in positive feelings and those that resulted in negative feelings. The positive column might include punctuality, concern, lack of jargon, fostering inquisitiveness, clear descriptions in layman's language, support, honesty, compassion, and accessibility. The negative column is likely to include pomposity, tardiness, apparent preoccupation, closing off of discussion, threats, belittling, blaming, and excessive regard for fiscal concerns.

4. *How do you think seeing your health providers socially would affect your feelings about being their patient?*

Likely feelings might include embarrassment, discomfort with role blurring, awkwardness regarding appropriate social conversation, embarrassment over physical issues or unhealthy behaviors, financial issues, and threats of breach of confidentiality.

5. *What are some of the values that need to be considered in weighing ethical decision-making in medicine?*

Dimensions that might be explored include: warmth versus intimacy, openness to inquiry versus inappropriate disclosure, societal versus personal good, financial stability versus greed, intellectualism versus emotionalism,; realistic versus unrealistic expectations in the patient, prevention versus treatment, and consensual risk-taking versus fear of legal action.

SECTION 7 ADDITIONAL EXERCISE

Assign a team of two people to each side of the following assertions and have the two teams debate the following assertions.

- Sexual relations between clinician and patient are acceptable if the clinician refers the patient to another provider.
- Clinicians cannot provide adequate care to members of their own families.

SECTION 8 SUGGESTED READING

1. Duckworth KS, Kahn MW, Gutheil TG. Roles, quandaries, remedies: Teaching professional boundaries to medical students. *Harvard Review of Psychiatry*. 1994;Jan-Feb:266–270.

   Reviews normal developmental issues that highlight professional boundaries for students and trainees on psychiatric rotations.

2. Epstein RS. *Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process.* Washington, DC: American Psychiatric Press; 1994.

   Examines issues such as informed consent, gifts, fees, confidentiality, abuses of power, and how clinicians can protect themselves from exploitative patients.

3. Gartrell NK, Milliken N, Goodson WH, et al. Physician-patient sexual contact: Prevalence and problems. *Western Journal of Medicine.* 1992;157(2):139–143.

   Discusses the epidemiology of physician-patient sexual contact. The largest study of its kind, this is an essential foundation for discussing physician-patient sex.

4. Gold JH, Nemiah JC (eds). *Beyond Transference: When the Therapist's Real Life Intrudes*. Washington, DC: American Psychiatric Press; 1993.

   Discusses how a psychotherapist's life outside the office may affect patients. Includes issues such as therapist illness, pregnancy, malpractice suits, and divorce. Because it is more specialized, it may be of less than optimal use for non-psychiatric practitioners.

SECTION 9 AUDIOVISUAL RESOURCES

1. **Ethical Concerns About Sexual Involvement Between Psychiatrists and Patients.** 1986. American Psychiatric Association. An educational tape that includes 13 vignettes in which actors portray situations from true incidents reported to the American Psychiatric Association Workgroup on Ethics. A discussion leader's guide accompanies the tape.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

2. **Mock Ethics Hearing.** 1991. Ethics Committee, American Psychiatric Association. This long video records a mock ethics hearing of a psychiatrist brought to court by his former wife. It includes charges of having a sexual relationship with a former patient and inadequately protecting patient confidentiality.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.

3. **Stressful Issues for Clinical Clerks.** 1994. Michael Meyers. This video presents vignettes of stressful situations facing medical students entering their clinical years. Although not all are relevant, it does include clinical relationships. Acted by medical students at St. Pauls Hospital, Vancouver, Canada.

   Contact: American Psychiatric Association. 800-366-8455 or 202-682-6349. Fax: 202-682-6189. E-mail: psrc@psych.org.